FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029660

Facility Name: MAYFIELD CARE CENTER

Address: 5905 W. WASHINGTON B (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 261-7074 **Fax #** (773) 261-2116

IDPA ID Number: 363336671001

Date of Initial License for Current Owners: 01/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY N. DRAZNER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,847	122	3,540	25,509	8
9	SNF/PED					9
10	ICF	26,325	148	483	26,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,172	270	4,023	52,465	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.14%

D. How many bed-hold days during this year were paid by Public Aid?
518 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,140

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,633	28,582	12,000	250,215		250,215		250,215			1
2	Food Purchase		270,372		270,372	(27,923)	242,450	(14)	242,436			2
3	Housekeeping	178,699	32,335		211,034		211,034	806	211,840			3
4	Laundry	67,309	13,809		81,118		81,118		81,118			4
5	Heat and Other Utilities			106,824	106,824		106,824	2,426	109,250			5
6	Maintenance	78,432	22,112	16,966	117,510		117,510	3,757	121,267			6
7	Other (specify):*							30	30			7
8	**TOTAL General Services**	534,073	367,210	135,790	1,037,073	(27,923)	1,009,151	7,005	1,016,155			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,907,934	93,814	41,953	2,043,701		2,043,701	(2,312)	2,041,389			10
10a	Therapy	100,246		9,863	110,109		110,109		110,109			10a
11	Activities	80,042	9,240	2,351	91,633		91,633		91,633			11
12	Social Services	54,858		4,785	59,643		59,643		59,643			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,143,080	103,054	64,952	2,311,086		2,311,086	(2,312)	2,308,774			16
	C. General Administration											
17	Administrative	186,748		72,000	258,748		258,748	12,077	270,825			17
18	Directors Fees											18
19	Professional Services			280,730	280,730	(17)	280,713	(224,333)	56,380			19
20	Dues, Fees, Subscriptions & Promotions			57,132	57,132		57,132	(29,568)	27,564			20
21	Clerical & General Office Expenses	46,754	27,684	167,992	242,430		242,430	(58,791)	183,639			21
22	Employee Benefits & Payroll Taxes			494,348	494,348	27,923	522,271		522,271			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,265	1,265		1,265	728	1,993			24
25	Other Admin. Staff Transportation			565	565		565	96	661			25
26	Insurance-Prop.Liab.Malpractice			5,079	5,079		5,079	141,854	146,933			26
27	Other (specify):*							29,481	29,481			27
28	**TOTAL General Administration**	233,502	27,684	1,079,111	1,340,297	27,906	1,368,203	(128,455)	1,239,747			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,910,655	497,948	1,279,853	4,688,456	(17)	4,688,439	(123,763)	4,564,676			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAYFIELD CARE CENTER #0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,825	19,825		19,825	221,474	241,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,390	4,390		4,390	418,447	422,837			32
33	Real Estate Taxes					17	17	43,855	43,872			33
34	Rent-Facility & Grounds			1,187,597	1,187,597		1,187,597	(1,187,597)	(0)			34
35	Rent-Equipment & Vehicles			27,632	27,632		27,632	(11,450)	16,182			35
36	Other (specify):*			37,500	37,500		37,500	(10,832)	26,668			36
37	**TOTAL Ownership**			1,276,944	1,276,944	17	1,276,961	(526,104)	750,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,513	222,730	380,243		380,243		380,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*	97,469			97,469		97,469	(97,469)	0			43
44	**TOTAL Special Cost Centers**	97,469	157,513	308,140	563,122		563,122	(97,469)	465,653			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,008,124	655,461	2,864,937	6,528,522		6,528,522	(747,336)	5,781,186			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,287	30		9
10	Interest and Other Investment Income	(5,476)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(313)	21		18
19	Entertainment				19
20	Contributions	(19,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,560)	21		24
25	Fund Raising, Advertising and Promotional	(8,302)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,650)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(173,578)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (320,905)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(426,431)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (426,431)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (747,336)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
MAYFIELD CARE CENTER

ID# 0029660
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (320)	21	1
2	IL Council on LTC - COPE	(2,579)	20	2
3	Marketing Salaries	(97,469)	43	3
4	VA Medical Expense	(2,641)	10	4
5	Capitalized R&M	(1,216)	06	5
6	Auto Lease Expense	(11,984)	35	6
7	Bank Charges Building Co	(145)	21	7
8	Nonallowable accounting fees	(5,000)	19	8
9	Building Co accounting fees	(10,675)	19	9
10	Seminar Marketing	(35)	24	10
11	Amortization - Building Co	(3,663)	31	11
12	Building Co Legal fees	(350)	19	12
13	Additional Rent Expense	(37,500)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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97				97
98				98
99				99
100				100
101	Total	(173,578)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(14)											(14)	2
3	Housekeeping			806									806	3
4	Laundry													4
5	Heat and Other Utilities			1,147		1,279							2,426	5
6	Maintenance	(1,216)		3,911		1,062							3,757	6
7	Other (specify):*					30							30	7
8	**TOTAL General Services**	(1,230)		5,864		2,371							7,005	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,641)		329									(2,312)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,641)		329									(2,312)	16
	C. General Administration													
17	Administrative			58,760	(47,258)	575							12,077	17
18	Directors Fees													18
19	Professional Services	(16,025)	11,025	(219,661)	162	166							(224,333)	19
20	Fees, Subscriptions & Promotions	(30,181)		570	38	5							(29,568)	20
21	Clerical & General Office Expenses	(145,988)	229	86,835	17	116							(58,791)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(35)		763									728	24
25	Other Admin. Staff Transportation			96									96	25
26	Insurance-Prop.Liab.Malpractice		141,055	692		107							141,854	26
27	Other (specify):*			28,674	807								29,481	27
28	**TOTAL General Administration**	(192,229)	152,309	(43,271)	(46,234)	969							(128,455)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(196,100)	152,309	(37,078)	(46,234)	3,340							(123,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	31,287	179,581	8,405	819	1,382							221,474	30
31	Amortization of Pre-Op. & Org.	(3,663)	3,663											31
32	Interest	(5,476)	421,372	316		2,234							418,447	32
33	Real Estate Taxes		41,833			2,022							43,855	33
34	Rent-Facility & Grounds		(1,187,597)	11,084		(11,084)							(1,187,597)	34
35	Rent-Equipment & Vehicles	(11,984)		534									(11,450)	35
36	Other (specify):*	(37,500)	26,668										(10,832)	36
37	**TOTAL Ownership**	(27,336)	(514,480)	20,339	819	(5,446)							(526,104)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(97,469)											(97,469)	43
44	**TOTAL Special Cost Centers**	(97,469)											(97,469)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(320,905)	(362,171)	(16,739)	(45,415)	(2,106)							(747,336)	45

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,187,597	Mayfield Building Limited	100.00%	$	$ (1,187,597)	1
2	V	32	Interest Income	2,873				(2,873)	2
3	V	21	Bank Charges				145	145	3
4	V	19	Legal & Professional Exp				350	350	4
5	V	32	Interest Expense				424,246	424,246	5
6	V	36	Mortgage Insurance				26,668	26,668	6
7	V	21	Office Expense				84	84	7
8	V	26	Property Insurance				141,055	141,055	8
9	V	30	Depreciation Expense				179,581	179,581	9
10	V	31	Amortization				3,663	3,663	10
11	V	33	Real Estate Taxes				41,833	41,833	11
12	V	19	Accounting Fees				10,675	10,675	12
13	V								13
14	Total			$ 1,190,470			$ 828,300	$ * (362,171)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 806	$ 806	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,147	1,147	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,911	3,911	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	329	329	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	56,226	56,226	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,235	1,235	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	570	570	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	86,835	86,835	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	763	763	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	96	96	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	692	692	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	28,674	28,674	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	8,405	8,405	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	316	316	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,084	11,084	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	534	534	30
31	V	19	HOME OFFICE	220,896	MANAGCARE, INC.	100.00%		(220,896)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	2,534	2,534	32
33	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%			33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 220,896			$ 204,157	$ * (16,739)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 24,742	$ 24,742	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	162	162	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	38	38	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	17	17	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	807	807	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	819	819	20
21	V								21
22	V	17	MANAGEMENT FEES	72,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(72,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 26,585	$ * (45,415)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,279	$ 1,279	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,062	1,062	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		30	30	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		575	575	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		166	166	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		5	5	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		116	116	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		107	107	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,382	1,382	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,234	2,234	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		2,022	2,022	25
26	V	34	RENT	11,084	MAZEL MANAGEMENT			(11,084)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,084			$ 8,978	$ * (2,106)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Mgmt/Admin	69.32%	See Attached	5	8.33%	Alloc. Sal	$ 24,742	17-7	1
2	Yosef Davis	Shareholder	Mgmt/Admin	69.32%	See Attached	5	8.33%	Salary	15,000	17-7	2
3	Moshe Davis	Shareholder	Administrative	0.25%	See Attached	4.8	12.00%	Alloc. Sal	2,534	17-7	3
4	Moshe Davis	Shareholder	Administrative	0.25%	See Attached	4.8	12.00%	Salary	50,274	17-7	4
5	Moshe Wolf	Shareholder	Administrative	1.34%	See Attached	12	21.43%	Alloc. Sal	14,932	17-7	5
6	Moshe Wolf	Shareholder	Administrative	1.34%	See Attached	12	21.43%	Alloc. Sal	575	17-7	6
7	Renita O'Connell	Shareholder	Administrative	1.34%	See Attached	9	21.43%	Alloc. Sal	16,830	17-7	7
8	Shoshana Braun	Shareholder	Clerical	0.25%	See Attached	3.3	8.25%	Salary	3,320	10-1	8
9	Chasida Davis	Relative	Clerical		See Attached	8.6	21.50%	Alloc. Sal	8,011	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 136,218		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,022,352	4	$ 3,731	$	220,896	$ 806	1
2	5	UTILITIES	BOOKEEPING INC.	1,022,352	4	5,310		220,896	1,147	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,022,352	4	18,100		220,896	3,911	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,022,352	4	1,521	1,521	220,896	329	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,022,352	4	260,224	260,224	220,896	56,226	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,022,352	4	5,715		220,896	1,235	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,022,352	4	2,636		220,896	570	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,022,352	4	401,889	331,028	220,896	86,835	8
9	24	SEMINARS	BOOKEEPING INC.	1,022,352	4	3,530		220,896	763	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,022,352	4	446		220,896	96	10
11	26	INSURANCE	BOOKEEPING INC.	1,022,352	4	3,203		220,896	692	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,022,352	4	132,710		220,896	28,674	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,022,352	4	38,898		220,896	8,405	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,022,352	4	1,461		220,896	316	14
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	1,022,352	4	51,300		220,896	11,084	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,022,352	4	2,474		220,896	534	16
17										17
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	7,405	7,405	14	2,534	18
19	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	7,547	7,547			19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 948,100	$ 607,725		$ 204,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 296,900	$ 296,900	5	$ 24,742	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	1,945		5	162	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	456		5	38	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	207		5	17	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	9,679		5	807	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	9,829		5	819	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 319,016	$ 296,900		$ 26,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC.	1,022,352	4	$ 5,921	$	220,896	$ 1,279	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	1,022,352	4	4,914	1,820	220,896	1,062	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	1,022,352	4	139		220,896	30	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	1,022,352	4	2,660		220,896	575	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	1,022,352	4	770		220,896	166	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	1,022,352	4	22		220,896	5	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	1,022,352	4	535		220,896	116	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC.	1,022,352	4	494		220,896	107	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC.	1,022,352	4	6,395		220,896	1,382	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	1,022,352	4	10,340		220,896	2,234	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	1,022,352	4	9,359		220,896	2,022	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 41,549	$ 1,820		$ 8,978	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Mortgage		X	Mortgage			$	$ 5,317,319			$ 424,246	1
2	Manufacturers		X	Line of Credit							2,421	2
3												3
4												4
5												5
	Working Capital											
6	Manufacturers		X	Short Term Loan							1,969	6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,317,319			$ 428,635	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(5,799)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,799)	14
15	TOTALS (line 9+line14)						$	$ 5,317,319			$ 422,837	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,668 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (8,349)	1
2	Allocation - Managecare	X									316	2
3	Allocation - Mazel	X									2,234	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (5,799)	21

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	45,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,855	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,145)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	17	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 52 For 95 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,872	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	32,594	8
1998	35,890	9
1999	42,788	10
2000	41,017	11
2001	41,833	12

2002 Accrual - 2001taxes 43855 x 1.03 = 45,000 (after rounding)

Refund has not been offset since it relates to a tax year which was not used to calculate a rate.

Related Party expense allocated $2006.65

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAYFIELD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-08-419-002-0000	Long-Term Care Property	$ 619.74	$ 619.74
2.	16-08-419-003-0000	Long-Term Care Property	$ 9,253.55	$ 9,253.55
3.	16-08-419-004-0000	Long-Term Care Property	$ 13,403.93	$ 13,403.93
4.	16-08-419-005-0000	Long-Term Care Property	$ 9,336.55	$ 9,336.55
5.	16-08-419-006-0000	Long-Term Care Property	$ 7,118.33	$ 7,118.33
6.	16-08-419-007-0000	Long-Term Care Property	$ 2,101.15	$ 2,101.15
7.	See attached	Allocation from Managecare/Mazel	$ 40,508.85	$ 2,006.65
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,342.10	$ 43,839.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAYFIELD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 168,991	1
2					2
3	TOTALS			$ 168,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156			1999	$ 1,595,648	$ 179,581	35	$ 79,782	$ (99,799)	$ 292,534	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	11,950		20	664	664	11,739	9
10	Various			1986	24,199		20	1,273	1,273	20,901	10
11	Various			1987	12,137		20	392	392	6,106	11
12	Various			1988	38,957		20	1,258	1,258	18,331	12
13	Various			1989	57,789		20	2,890	2,890	39,139	13
14	Various			1990	40,078		20	1,391	1,391	24,330	14
15	Various			1991	34,073		20	1,704	1,704	19,171	15
16	Various			1992	1,200		20	60	60	650	16
17	Various			1993	6,071		20	304	304	2,847	17
18	Various			1994	24,281		20	1,214	1,214	9,988	18
19	Various			1995	1,467		20	73	73	543	19
20	Various			1996	64,140		20	3,207	3,207	20,980	20
21	Various			1997	15,923		20	796	796	4,423	21
22	Various			1998	966,314		20	48,318	48,318	201,403	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		56,808	2,939		2,495	(444)	38,271	68
69	Financial Statement Depreciation			19,825			(19,825)		69
70	TOTAL (lines 4 thru 69)		$ 2,951,035	$ 202,345		$ 145,821	$ (56,524)	$ 711,356	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,951,035	$ 202,345		$ 145,821	$ (56,524)	$ 711,356	1
2	FIRE PUMP & MOTOR	1999	9,249		20	462	462	1,771	2
3	ELECTRICAL WORK	1999	5,351		20	268	268	983	3
4	FENCE	1999	6,975		20	349	349	1,309	4
5	FIRE ALARM SYSTEM	1999	5,563		20	278	278	996	5
6	STAIRWAY WORK	1999	2,850		20	143	143	572	6
7	FLOOR DRAINS	1999	2,000		20	100	100	358	7
8	ALARM	1999	4,507		20	225	225	900	8
9	VIDEO PROCESSOR	1999	3,832		20	192	192	608	9
10	DESK & CABINETS	1999	2,600		20	130	130	520	10
11	DESK & CABINETS	1999	5,825		20	291	291	897	11
12	BATHTUB	1999	1,220		20	61	61	198	12
13	ELECTRICAL ENGINEER	1999	1,260		20	63	63	226	13
14	PAINTING	1999	3,300		20	165	165	601	14
15	REMODELING	1999	40,449		20	2,022	2,022	7,246	15
16	CONSTRUCT SUPPLIES	1999	1,223		20	61	61	219	16
17	ARCHITECT SUPPLIES	1999	2,082		20	104	104	373	17
18	CUBICLE CURTNS, TILE	1999	2,147		20	107	107	384	18
19	NURSE CALL SYSTEM	1999	419		20	21	21	69	19
20	ALARM SYSTEM	1999	1,081		20	54	54	234	20
21	PAINTING	1999	1,585		20	79	79	284	21
22	SEAL COATING	1999	1,791		20	90	90	345	22
23	INTERCOM SYSTEM	1999	847		20	42	42	162	23
24	VIDEO SECURITY SYSTM	1999	2,266		20	113	113	433	24
25	CCTV SYSTEM	1999	2,184		20	109	109	418	25
26	CCTV SYSTEM	1999	1,559		20	78	78	299	26
27	PUBLIC ADDRESS SYSTM	1999	880		20	44	44	168	27
28	WALK IN REFRIG REPAI	1999	1,405		20	70	70	280	28
29	COPPER PIPE	1999	1,475		20	74	74	296	29
30	TELECOMM SYSTEM	1999	1,105		20	55	55	201	30
31	FIRE PROTECTION	1999	3,290		20	165	165	673	31
32	HOT WATER SYSTEM	1999	1,576		20	79	79	369	32
33	ELECTRIC DOOR HOLDER	1999	527		20	26	26	82	33
34	TOTAL (lines 1 thru 33)		$ 3,073,458	$ 202,345		$ 151,941	$ (50,404)	$ 733,830	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,073,458	$ 202,345		$ 151,941	$ (50,404)	$ 733,830	1
2	CCTV SYSTEM	1999	1,154		20	58	58	184	2
3	NURSE CALL SYSTEM	1999	348		20	17	17	53	3
4	CCTV SYSTEM	1999	762		20	38	38	120	4
5	ALARM SYSTEM	1999	1,392		20	70	70	228	5
6	ROOF FLASHERS	1999	1,000		20	50	50	179	6
7	COPPER PIPE	1999	1,200		20	60	60	215	7
8	WRAP / LAMPS	1999	1,502		20	263	263	263	8
9	LOCKS / KEY BLANKS	1999	1,942		20	340	340	340	9
10	ELECTRICAL ENGINEERING	1999	1,260		20	221	221	221	10
11	ARCHITECT	1999	2,956		20	517	517	517	11
12	MECHANICAL / PLUMBING	1999	1,435		20	251	251	251	12
13	FIRE DAMPERS	2000	7,044		20	352	352	1,027	13
14	FIRE DAMPERS	2000	1,000		20	50	50	142	14
15	FIRE DAMPERS	2000	4,920		20	246	246	718	15
16	ALARM SYSTEM	2000	1,866		20	93	93	248	16
17	ELECTRICAL WORK	2000	4,814		20	241	241	603	17
18	NEW MAIN LINES	2000	2,775		20	139	139	359	18
19	SURVEY	2000	750		20	38	38	101	19
20	AWING	2000	8,500		20	850	850	2,479	20
21	FENCE	2000	1,250		20	125	125	375	21
22	NEW PUMP UNIT	2000	6,800		20	680	680	1,700	22
23	CIRCUIT BREAKER/CMPR	2000	3,982		20	199	199	398	23
24	FIRE DAMPERS	2001	4,723		20	472	472	826	24
25	KITCHEN FAN	2001	2,000		20	100	100	200	25
26	CARPET	2001	1,049		20	52	52	69	26
27	ELEVATOR MOTOR	2001	1,800		20	90	90	98	27
28	NEW CEILING & LIGHTING	2002	9,712		20	728	728	728	28
29	COMPRESSOR,FAN BLADE & MOTOR	2002	3,341		20	139	139	139	29
30	PLUMBING	2002	1,216		20	61	61	61	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,155,951	$ 202,345		$ 158,481	$ (43,864)	$ 746,672	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5			1985		22,291	1,159	20	743	(416)	12,817	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - Mazel Management			2001	468	12	20	47	35	69	9
10	Allocation - Mazel Management			2000	237	6	20	12	6	27	10
11	Allocation - Mazel Management			1998	834	28	20	42	14	196	11
12	Allocation - Mazel Management			1997	778	20	20	39	(19)	207	12
13	Allocation - Mazel Management			1996	530	6	20	27	21	174	13
14	Allocation - Mazel Management			1995	120	3	20	6	3	45	14
15	Allocation - Mazel Management			1994	473	9	20	24	15	176	15
16	Allocation - Mazel Management			1993	280	8	20	14	6	132	16
17	Allocation - Mazel Management			1991	210	7	20	10	3	113	17
18	Allocation - Mazel Management			1990	325	7	20	16	9	201	18
19	Allocation - Mazel Management			1989	204	5	20	9	4	116	19
20	Allocation - Mazel Management			1987	463	9	20	8	(1)	463	20
21	Allocation - Mazel Management			1986	1,869	97	20	80	(17)	1,584	21
22	Allocation - Mazel Management			1985	130					130	22
23											23
24	Allocation - ManageCare			1997	2,599	232	20	260	28	1,408	24
25	Allocation - ManageCare			1993	204		20	20	20	98	25
26	Allocation - ManageCare			1988	318	10	20	16	6	227	26
27	Allocation - ManageCare			1986	24,107	1,231	20	1,104	(127)	20,063	27
28											28
29	Allocation - InterCare			2001	368	90	20	18	(72)	25	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 56,808	$ 2,939		$ 2,495	$ (482)	$ 38,271	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 828,467	$ 1,871	$ 79,825	$ 77,954	10	$ 366,377	71
72	Current Year Purchases	5,313	827	526	(301)	10	526	72
73	Fully Depreciated Assets	123,908				10	123,862	73
74								74
75	TOTALS	$ 957,688	$ 2,698	$ 80,351	$ 77,653		$ 490,765	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated - Managecare	2000	$ 36,566	$ 4,329	$ 1,796	$ (2,533)	5	$ 8,830	76
77		Allocated - Intercare	2002	4,460	638	669	31	5	669	77
78										78
79										79
80	TOTALS			$ 41,026	$ 4,967	$ 2,465	$ (2,502)		$ 9,499	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,323,656	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	210,010	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	241,297	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	31,287	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,246,936	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Certificate of Need - 1900	$ 905,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 905,000	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Mayfield Building

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 16,182 Description: Special Beds $15648; Allocated from Managecare $534
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 83,723	$		$ 83,723	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			57,041			57,041	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			81,966			81,966	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				69,768		69,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					29,865		29,865	12
13	Other (specify): See Supplemental						57,880		57,880	13
14	TOTAL			$		$ 222,730	$ 157,513		$ 380,243	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 240,061	$ 252,374	1
2	Cash-Patient Deposits	4,069	4,069	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	806,943	806,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,418	75,418	6
7	Other Prepaid Expenses	11,087	133,487	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	38,817	425,038	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,176,395	$ 1,697,329	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,991	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	50,800	1,165,824	15
16	Equipment, at Historical Cost	65,909	1,109,421	16
17	Accumulated Depreciation (book methods)	(50,638)	(1,296,707)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	139,675	1,006,028	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 205,746	$ 3,854,205	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,382,141	$ 5,551,534	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 447,784	$ 447,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,781	124,781	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,189	12,189	31
32	Accrued Real Estate Taxes(Sch.IX-B)		45,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 584,754	$ 629,754	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,317,319	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,317,319	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 584,754	$ 5,947,073	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 797,387	$ (395,539)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,382,141	$ 5,551,534	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 449,830	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 449,830	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(152,443)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ADDITIONAL PAID IN CAPITAL	800,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 347,557	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 797,387	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,151,266	1
2	Discounts and Allowances for all Levels	(605,852)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,545,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	587,836	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 587,836	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,655	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	100,415	19
20	Radiology and X-Ray		20
21	Other Medical Services	70,350	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 232,420	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,602	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,602	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,807	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,807	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,376,079	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,037,073	31
32	Health Care	2,311,086	32
33	General Administration	1,340,297	33
	B. Capital Expense		
34	Ownership	1,276,944	34
	C. Ancillary Expense		
35	Special Cost Centers	477,712	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,528,522	40
41	**Income before Income Taxes (line 30 minus line 40)****	(152,443)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (152,443)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,344	1,392	$ 42,991	$ 30.88	1
2	Assistant Director of Nursing	232	240	7,843	32.68	2
3	Registered Nurses	32,474	10,783	280,336	26.00	3
4	Licensed Practical Nurses	36,836	40,929	737,945	18.03	4
5	Nurse Aides & Orderlies	85,973	91,362	795,587	8.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,083	8,057	100,246	12.44	8
9	Activity Director	1,928	2,124	21,762	10.25	9
10	Activity Assistants	7,118	7,661	58,280	7.61	10
11	Social Service Workers	5,332	5,736	54,858	9.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,519	23,471	209,633	8.93	15
16	Dishwashers					16
17	Maintenance Workers	10,004	10,579	78,432	7.41	17
18	Housekeepers	21,947	23,340	178,699	7.66	18
19	Laundry	9,023	9,786	67,309	6.88	19
20	Administrator	2,008	2,160	77,761	36.00	20
21	Assistant Administrator	2,024	2,160	43,096	19.95	21
22	Other Administrative	2,379	2,579	65,891	25.55	22
23	Office Manager					23
24	Clerical	4,448	4,933	46,754	9.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,731	4,183	43,232	10.34	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,379	2,579	97,469	37.79	33
34	TOTAL (lines 1 - 33)	257,781	254,053	$ 3,008,124 *	$ 11.84	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,000	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	2	169	10-03	38
39	Pharmacist Consultant	Monthly	7,409	10-03	39
40	Physical Therapy Consultant	27	2,512	10a-03	40
41	Occupational Therapy Consultant	31	3,137	10a-03	41
42	Respiratory Therapy Consultant	59	2,124	10a-03	42
43	Speech Therapy Consultant	9	2,090	10a-03	43
44	Activity Consultant	43	2,351	11-03	44
45	Social Service Consultant	87	4,785	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	257	$ 46,705		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,073	10-03	50
51	Licensed Practical Nurses	881	28,918	10-03	51
52	Nurse Aides	32	256	10-03	52
53	TOTAL (lines 50 - 52)	938	$ 30,247		53

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joshua Weinstein	Administrator	0	$ 77,761
Patricia Holly	Asst Admin	0	43,096
Moshe Davis	Admin. Consult	.25%	50,891
Yosef Davis	Admin. Consult	69.32%	15,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 186,748

B. Administrative - Other

Description	Amount
Intercare - Management Fees	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Econocare	Purchasing Consultant	$ 2,700
Global Human Resource	IOC Consultant	2,443
Personnel Planners	Unemployment Consultant	7,713
Jacobs Healthcare	Computer	300
American Data	Computer	3,600
Schmidt, Saltzman	Legal	17
Ungaretti & Harris	Legal	790
Myers & Miller	Legal	726
Managecare	Bookkeeping	220,896
Frost Ruttenberg & Rothblatt	Accounting	41,545
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 280,730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,147
Unemployment Compensation Insurance	52,453
FICA Taxes	227,072
Employee Health Insurance	122,885
Employee Meals	27,923
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	5,093
Pension	23,276
Disability Insurance	4,220
Employee Benefits	7,157
Holiday Expense	1,044
TOTAL (agree to Schedule V, line 22, col.8)	$ 522,271

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	14,984
Health Care Worker Background Check	3,536
(Indicate # of checks performed 108)	
Licenses & Fees	2,363
Advertising & Promotion	8,302
IL Council on LTC	5,868
Alloc Managecare	570
Alloc Mazel	38
Alloc Intercare	5
Less: Public Relations Expense	( )
Non-allowable advertising	(8,302)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,564

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,230
Allocated from ManagCare	763
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,993

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $8447**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,351** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **27,923** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees